

# ***Exhibit 9***

**Choice House Calls**  
17200 E. 10 Mile Road, Suite 135  
Eastpointe, MI 48021  
Phone: 1-586-279-3200

**INITIAL EVALUATION**

Patient ID: 1281510  
Patient Name:   
Date of Birth:   
Date of injury: 03/21/2010  
Date of Reevaluation: 03/31/10

**CURRENT COMPLAINTS:**

MVA.

**HISTORY OF PRESENT ILLNESS:**

This is a female driver that was involved in an vehicle accident on 03/21/2010. She was stopped at the light and rear ended while sitting as the passenger with her boyfriend in the same vehicle. The impact was severe, and both were shaken up quite a bit and was wearing a seatbelt. Airbags did not deploy although the car was equipped with them. EMS was not called. The police showed up and said they were fine then they could go to the hospital, but EMS was not necessary. The patient did not go to the ER that day but woke the next day in severe pain. Cervical pain was described as 5/10 radiating into the right elbow and was dull in quality. Thoracic spine was within normal limits. Lumbar spine was 5/10 and dull bilateral radiation to the gluteal region and also left knee pain was noted 4/10 and dull that hurts while walking down the stairs more than up the stairs. Overall, she complained of headaches, neck pain, back pain, and also left knee. They said the approximate speed of the vehicle that hit them was about 50 miles an hour from what she could see in the rear view mirror.

**REVIEW OF SYSTEMS:**

As per HPI.

**PAST MEDICAL HISTORY:**

Carpal tunnel on the right.

**PAST SURGICAL HISTORY:**

Only includes some teeth pulling. The patient had diabetes during pregnancy. She is not pregnant at this time.

**FAMILY HISTORY:**

Positive for heart condition in her father and lung condition in her mother, but she does not know the types of the conditions. She just had a baby on 03/17/2009, healthy baby.

**OBJECTIVE FINDINGS:**

Vitals at the time of our examination, the patient has temperature 97 degrees Fahrenheit and pulse oximetry 97%, pulse 100, blood pressure 124/82, her height was 62 inches, and she weighed 185 pounds. General: She was well-nourished and developed in no acute distress except for the mild discomfort secondary to the pain that she described. She was awake, alert, and oriented x4. HEENT: Normocephalic and atraumatic. Pupils are equally, round, and reactive to light and accommodation. Extraocular muscles are intact.

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Patient ID: 1281510

Patient Name:

Date of Birth:

Date of injury: 03/21/2010

Date of Reevaluation: 03/31/10

Cardiovascular: S1 and S2. No murmur, rubs, and gallops. Pulmonary exam: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, and nondistended. Bowel sounds x4 normoactive.

Extremities: Full range of motion. No clubbing, cyanosis, or edema. There was muscle strength at 5/5. Neurological exam consistent with a cervical spine analysis with tissue texture abnormality, assymetry, restriction of motion, and tenderness to palpation over C5, C6, and C7. Paraspinal muscle contractions were noted that are moderate in severity. Thoracic spine was analyzed and was positive only for paraspinal muscle contractions around the VI, VII, and VIII. These were moderate in significance. Also, there was point tenderness in the spinous process at T7. The range of motion was decreased in both approximately 20% in all aspects worse with rotation. The lumbar spine was examined and was positive for tender point in the transverse processes as well as spinous process of L4 and L5 this was very mild paraspinal muscle spasms that were noted. The straight leg test was performed and was negative. Pinprick and sensation were intact. Muscle strength was 5/5 that was already noted.

**CURRENT DIAGNOSES:**

1. Cervical strain rule out radiculopathy.
2. Thoracic strain rule out radiculopathy.
3. Lumbar strain rule out radiculopathy.

**RECOMMENDATIONS:**

1. Physical therapy three sessions per week x1 month.
2. The patient instructed to take muscle relaxer Valium 10 mg one p.o. b.i.d. #60 dispensed and Motrin for pain 600 mg one p.o. b.i.d. #60 dispensed. The patient did not want narcotic. The patient wanted to take care of the baby. She understood that Valium may make her feel a little bit loopy but she is okay. She will only take at night to sleep while the husband takes care of the baby.
3. Reevaluation will take in 30 days. The patient understood states she will comply our instruction and care.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems

DD: 03/31/10

DT: 05/13/10

PTV/WF/

**Mundy Pain Clinic P.C.**  
6240 Rashelle Drive, Suite 103  
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Phone: 810-232-9800  
Fax: 810-232-7710

**INITIAL EVALUATION**

Patient ID: 3080  
Patient Name:   
Date of Birth:   
Date of Injury: 04/23/2010  
Date of Initial Evaluation: 05/20/2010

**CHIEF COMPLAINT: MVA.**

**HISTORY OF PRESENT ILLNESS:** This is a 49-year-old African-American female driver that was involved in a motor vehicle collision. She was rear ended at an unknown rate of speed but it was fast according to the patient while she was stopped at a red light. She was wearing a seatbelt. The airbags were not deployed though the vehicle was equipped. She did obtain a police report. EMS did not show up and nor did not go to the hospital. She states that she was shaken up by the accident quite a bit; however, her emotional state surpassed that of her physical complaint, so she opted to go home instead. When she woke up the next morning, she found herself to be in pain. Cervical pain was a 7/10 in quality and sharp quality, bilateral radiation with paresthesias upto the fingertips were noted. The thoracic spine was 7/10 and radiating to the right towards her chest around the flank. Her lumbar spine is worse, this is 10/10, sharp and bilateral radiation to the back of her knees. Additionally, the patient has had posttraumatic headaches approximately four episodes a week lasting one to two hours. These resolved only with excess use of over-the-counter medication for headaches.

**REVIEW OF SYSTEMS:** As per HPL.

**MEDICATIONS:** None.

**ALLERGIES:** Penicillin which gives her hives.

**PRIOR INJURIES OR ACCIDENTS:** None.

**PRIOR SURGICAL PROCEDURES:** She had a cesarean section x1.

**PRIOR HOSPITALIZATIONS:** None.

**FAMILY HISTORY:** Noncontributory.

**SOCIAL HISTORY:** She is married. Denies alcohol. Denies tobacco use. She works as a nursing home aide.

**LAST DATE WORKED:** Presently working.

**EDUCATION:** High school completion.

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Patient ID:

3080

Patient Name:

Date of Birth:

Date of Injury:

04/23/2010

Date of Initial Evaluation: 05/20/2010

**PHYSICAL EXAMINATION:** Vitals: She had a blood pressure of 136/84, pulse 72, and respirations 15. She is 5 feet 10 inches and weighs 149 pounds. General: Well nourished and developed, in no acute distress, alert and oriented x4. HEENT: Head is normocephalic and atraumatic. Pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Cardiovascular: S1, S2. No murmurs, rubs, or gallops. Pulmonary: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, and nondistended. Bowel sounds x4, normoactive. Extremities: Full range of motion. No clubbing, cyanosis, or edema. Neurological Examination: Cervical spine palpation on the vertebral aspects of spinous processes and transverse processes revealed paraspinal musculature tenderness of a mild-to-moderate nature as well as spinous processes tenderness from C3 to C7 diffusely. Spurling's test was performed and it was positive bilateral up to the fingers with paresthesias. Rotation, flexion, extension of the cervical spine was reduced to approximately 40%. Sensation slightly decreased. Vibration intact. Thoracic spine examination was within normal limits. Lumbar spine examination, palpatory findings were that of moderate to severe paraspinal muscle spasm with tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation along the spinous processes of L3, L4, and L5. Flexion and extension of lumbar spine was reduced to approximately 25%. Straight leg test was performed and was positive bilateral 30 and 35 degrees respectively, left and right. Muscle strength 5/5. Deep tendon reflexes 2/4. Gait was stable.

**DIAGNOSES:**

1. Cervical strain, rule out radiculopathy.
2. Thoracic strain, rule out radiculopathy.
3. Lumbar strain, rule out radiculopathy.
4. Posttraumatic headaches.

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Patient ID: 3080

Patient Name:

Date of Birth:

Date of Injury: 04/23/2010

Date of Initial Evaluation: 05/20/2010

**RECOMMENDATIONS:**

1. Physical therapy and occupational therapy three sessions a week x4 weeks.
2. Pharmacotherapy with Valium 10 mg one p.o. t.i.d. #60 dispensed and pain medication with Lortab 7.5/500 mg one p.o. t.i.d. #90 dispensed. Additionally, the patient is to wear a lumbar brace which has been prescribed to her at this time and reevaluation to take place in 30 days. Physical therapy goals to restore motor deficits, increase range of motion, and reduction of pain.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems

DD: 08/05/10

DT: 08/06/10

PTV/WF/MW

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**INITIAL EVALUATION**

**Patient ID:** 2990  
**Patient Name:**   
**Date of Birth:**   
**Date of Onset:** 04/27/10  
**Date of Reevaluation:** 5/18/10

**CHIEF COMPLAINT:** MVA.

**HISTORY OF PRESENT ILLNESS:** A 54-year-old African-American female driver who hit on the driver door side by a parallel vehicle that was driving by, slammed on the break, and skid into her as she was stopped at a red light. The patient admits to wearing a seat belt but says the airbag did not deploy although it was equipped with airbags. She obtained a police report and EMS did not show up at the scene. She took herself to Genesis for evaluation. The patient says she had hit her head and had cervical pain that was 7/10, sharp and dull, intermittently radiating to the left shoulder. Additionally, the patient had headaches that was 4/10 in pain and impact site where she hit her head was positive for swelling. The patient went to Hurley where she had a negative CT for head bleeds and thoracic spine which was within normal limits and the lumbar spine was diagnosed with a strain, but complaining to be a 4/10 radiating to the left back of the knee. Left ankle was also strained, 4/10 in pain, and local.

**PAST MEDICAL HISTORY:** Seizure disorder, currently negative.

**PAST SURGICAL HISTORY:** Positive only for history of migraine.

**MEDICATIONS:** Include Vicodin 5/500 and Flexeril 10 mg given to her by her primary care physician for her MVA and previous Depakote prescription 500 mg was given for migraine.

**DRUG ALLERGIES:** Sulfa drugs.

**PRIOR INJURIES:** None.

**PRIOR SURGICAL PROCEDURES:** She had a dilatation and curettage performed as well as a wrist surgical tendon repair in 1975.

**PRIOR HOSPITALIZATIONS:** For the dilatation and curettage as well as the surgical tendon repair.

**FAMILY HISTORY:** Noncontributory.

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Patient ID: 2990

Patient Name:

Date of Birth:

Date of Onset: 04/27/10

Date of Reevaluation: 5/18/10

**SOCIAL HISTORY:** She admits to occasional alcohol and tobacco. She is currently unemployed and receiving pension.

**PHYSICAL EXAMINATION:** She is 5 feet 10 inches tall and 165 pounds. Vitals: Blood pressure 142/84, respirations 16, temperature was within normal limits, and pulse was 80. General: She is well nourished and well developed, in mild distress secondary to her pain complaints. Awake, alert, and oriented x4; and cooperative. HEENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light and accommodation. Extraocular muscles are intact. Cardiovascular exam, S1 and S2. No murmurs, rubs, or gallops. Pulmonary exam, clear to auscultation bilaterally. No wheezing, rales, or rhonchi. The abdomen is soft, nontender, and distended. Bowel sounds are normoactive. Extremities: Full range of motion without clubbing, cyanosis, or edema. Neurologic exam, Cranial nerves II through XII intact. No focal deficits. Pronator drift was negative. The gait was stable. Deep tendon reflexes were 2/4. Musculoskeletal exam, she had cervical pain that was assessed and it was positive for tissue texture abnormality, asymmetry, restriction in motion, and tenderness to palpation over the spinous processes of C4-C7. There were mild to moderate paraspinal muscle spasms. Sensation and vibration, however, were intact. Spurling's test performed was negative. The patient had left ankle pain. This was assessed with range of motion and anterior drawer. There was some decrease in active range of motion as well as passive range of motion of the left ankle which produced tenderness to palpation over the medial and lateral aspects of the malleoli. The left shoulder was assessed for pain independent of the cervical and radicular pattern that the patient complained about. It was found to be decreased in range of motion and painful through abduction and adduction consistent with a possible shoulder strain rather than cervical radiculopathy. The area was warm to the touch and inflamed. Lumbar spine was positive for paraspinal muscle spasms, mild to moderate in nature and tender points between L3 and L5, although the straight leg test performed was negative.

**RECOMMENDATIONS:**

1. Physical therapy three sessions a week x4 weeks.
2. The patient has medications currently that are given by her primary care physician so at this time, pharmacotherapy will not be reemployed. The patient is to take prescription medication as indicated.
3. Followup with physical therapy.

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**Page 3 of 3**

**Patient ID:** 2990

**Patient Name:**

**Date of Birth:**

**Date of Onset:** 04/27/10

**Date of Reevaluation:** 5/18/10

4. Reevaluation will take place in 30 days.
5. Physical therapy goals would be restoration of motor deficits, reduction of pain, and increase in range of motion.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems

DD: 08/25/10

DT: 08/30/10

PTV/TAN/MW

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**INITIAL EVALUATION**

Patient ID:

Patient Name:

Date of Birth:

Date of Injury:

Date of Evaluation:

August 2010

02/08/2011

22B149519

Page 1 of 3

The patient was not sure of date of injury, some time in August 2010.

**HISTORY OF PRESENT ILLNESS:** The patient was a belted driver. He stated the car he was driving was T-boned to the passenger side. The patient states the driver's airbag deployed. The patient states he may have been knocked out for a very brief moment. He stated the airbag deployed in to his face area. The patient stated when he came to, he got out of the car to make sure the other person in the other car was okay. He states the EMS arrived but he did not feel he needed medical attention at that time. The patient apparently has not had any medical attention presumably, he states, because he has no insurance. He stated may be three or four days after the accident he started noticing some headaches. He stated he went to the McLaren ER where they said they were migraines and he was sent home. The patient did not tell the ER physician that he had been in a car accident a few days prior. The patient stated that he would get occasional sharp pain in his neck and low back following the accident, but he it was very intermittent and was not causing him much difficulty until, he stated, about a month or so thereafter the accident when the neck and low back pain became more intense and more consequent. The patient states that he continues to have headache. They are at the front of his head. No nausea or vomiting. He states sometimes they may be throbbing in nature. There is no neurologic deficit noted. He states he is experiencing some occasional memory loss. He states that sometimes he will put something down like a glass of water and then forget where he put it. The headaches are not everyday. They come and go. He states his neck pain is about 8/10. He states there seems to be, what he is describing, some right-sided radiculopathy and he has paresthesias and both hands, he states. His low back pain, he states, is localized, there are no radiculopathy symptoms, no paresthesias, and gives that about 7/10 on the pain scale. The patient has not been taking any pain medication. The patient has no other complaints.

**PAST MEDICAL HISTORY:** Positive for hypertension, non-insulin-dependent diabetes, schizophrenic paranoia, glaucoma, cataracts, asthma, and panic attacks. He states the panic attacks started about three or four months ago and he is not sure what is trigger those, but they were not there before the accident.

**MEDICATIONS:** He is not sure of the names of. He will bring the names of his medications at next visit, but ostensibly they are medications for the above-mentioned medical conditions.

**ALLERGIES:** He has no drug allergies.

**SIGNIFICANT PRIOR INJURIES AND ACCIDENTS:** He has no prior injuries or accidents.

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**INITIAL EVALUATION**

Patient ID:

Patient Name:

Date of Birth:

Date of Injury: August 2010

Date of Evaluation: 02/08/2011

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**PAST SURGICAL HISTORY:** The patient has a surgical procedure nine months ago he stated, for rectal cancer. There is no chemotherapy, just stated it was an outpatient surgery for rectal cancer, so I am not sure if this is truly what his condition was or this is what he was led to believe it was. He had no prior hospitalizations.

**FAMILY AND SOCIAL HISTORY:** He is single. He has six children ages 25 to 16. The 16-year-old lives with the child's mother. The patient does not drink or smoke cigarettes. The patient was laid off in July 2010. He had worked as a General Motors supplier. The patient's education, he is a high school graduate and he is presently attending a learning center four days a week.

**PHYSICAL EXAMINATION:** Vitals: Blood pressure of 140/90. Pulse 80. Respirations 14. The patient appears to be in some distress due to his injuries. He is alert. He is oriented x3. **HEENT:** Pupils are equally round and reactive to light. Extraocular muscles are intact. C-spine reveals tenderness to palpation over the spinous processes C3 through C7 with cervical paraspinal tenderness, left greater than the right. Range of motion is just restricted in the horizontal plane. Lungs are clear. Heart: S1 and S2 normal without murmur. Abdomen is benign. Thoracic spine is nontender. Lumbar spine, there is tenderness to palpation over the lumbar spinous processes L2 through L5 with bilateral lumbar paraspinal tenderness. Range of motion is decreased in all planes. Negative straight leg raise bilaterally. DTRs are +2 bilaterally in upper and lower extremities. Handgrip is strong bilaterally. Right shoulder reveals tenderness to palpation over the anterosuperior aspect. Range of motion is decreased in all planes and he is unable to raise his right arm above shoulder level.

**IMPRESSION:**

1. Status post MVA with subsequent cervical radiculopathy.
2. Lumbar strain.
3. Right shoulder derangement.
4. Postconcussive headaches with possible memory loss.
5. Paranoid schizophrenic.
6. Hypertension.
7. Non-insulin-dependent diabetes.
8. Glaucoma.
9. Asthma.
10. Cataracts.
11. Panic attacks.

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**INITIAL EVALUATION**

Patient ID:

Patient Name:

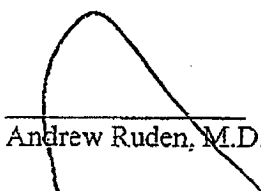
Date of Birth:

Date of Injury: August 2010

Date of Evaluation: 02/08/2011

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PLAN: We will get MRI of his C-spine and right shoulder. I will get a neuropsychic evaluation or occupational therapy to his right shoulder and head. Physical therapy to his C-spine and lumbar spine. He is considered disabled. Vicodin ES one b.i.d., dispensed #60; Xanax 1 mg one b.i.d., dispensed #60. Recheck in 30 days.



Andrew Ruden, M.D.

Transcribed by JJ Medical Systems

DD: 02/08/11

DT: 02/09/11

FV

Medical Evaluation  
20411 W. 12 Mile Rd.  
Southfield, MI 48076  
Phone: 248-354-1111 Fax: 248-354-1114

**INITIAL OFFICE EVALUATION**

**Patient Name:**   
**Date of Birth:**   
**Date of Onset:** 07/27/09  
**Date of Dictation:** 08/17/09

**HISTORY OF PRESENT ILLNESS:** The patient was a non-belted passenger in the rear, sitting behind the driver side. The patient states the vehicle he was in was struck to the front driver side. The patient states that his left side of his head struck the window. He said there was no loss of consciousness but became dizzy, almost immediately. A few minutes later, the dizziness had disappeared. There were no other injuries at that time, but a day or two later, he says, the neck became more painful and more stiff and noticed some tingling in both hands. The patient states that since the accident, he has noticed his memory is not the same. He seems to be forgetting a lot, but at least forgetting things that he normally would remember and does not seem to be as sharp mentally, he says. He denies any nausea, vomiting, or any tenderness. He gets an occasional headache. The patient has not sought medical attention for any of these injuries. He has no other acute injury secondary to this motor vehicle accident other than the neck pain with some tingling in the hands with occasional pain into his upper arms and his memory loss with occasional headache. The patient also states he sometimes has difficulty sleeping.

**PAST MEDICAL HISTORY:** The patient is positive for depression and hypertension.

**FAMILY HISTORY:** Negative for high blood pressure, diabetes, or MI.

**MEDICATIONS:** The patient takes blood pressure medicine. He is not sure the name of it and he takes antidepressant. He takes Aleve over-the-counter.

**ALLERGIES:** He has no drug allergies.

**PRIOR INJURIES AND ACCIDENTS:** He has work related back injury from which he is disabled.

**PAST SURGICAL HISTORY:** He has also had prior surgical procedures for his ankle and knee and hand.

**PRIOR HOSPITALIZATION:** Depression and suicide attempts. The patient presently is on disability for his low back injuries as well as his ankle and leg injuries.

Medical Evaluation  
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Page 2

Patient Name:   
Date of Birth:   
Date of Onset: 07/27/09  
Date of Dictation: 08/17/09

**FAMILY AND SOCIAL HISTORY:** He is single. He drinks occasional alcohol. Smokes an occasional cigarettes.


**WORK HISTORY:** He has not worked since 1997.

**EDUCATION:** He went through two years of college.

**PHYSICAL EXAMINATION:** He is 5 feet and 8 inches and 180 pounds. Blood pressure is 140/80. Pulse is 72. Respirations 14. The patient is alert and oriented x 3. No hematoma is noted to the scalp. Pupils are equal, round, and reactive to light. C-spine, there is some tenderness to the spinous processes, 3 through 5. There is some palpable tenderness to the paraspinals bilaterally. Hand grip is strong bilaterally. Sensory exam is intact. The upper extremity, DTRs are +2 bilaterally. Lungs are clear. Heart; S1 and S2 noted without murmur. There is some lumbar tenderness to palpation. He says it is not from the injury. This is from his old back injury. DTRs are +2 bilaterally in lower extremities.

**IMPRESSION:** Status post motor vehicle accident with cervical radiculopathy bilaterally, closed head injury, history of depression, and hypertension.

**RECOMMENDATIONS:** MRI of his neck and head. Physical therapy to his cervical region. Prescriptions for Vicodin and Soma. He is considered disabled. He will be rechecked in 30 days.



Andrew J. Ruden, M.D.

**Choice House Calls**  
17200 E. 10 Mile Road, Suite 135  
Eastpointe, MI 48021  
Phone: 1-866-688-3679

**INITIAL OFFICE VISIT**

Patient ID: 1275660

Patient Name:

Date of Birth:

Date of Onset: 01/06/10

Date of Evaluation: 01/20/10

**CHIEF COMPLAINTS:**

Neck and mid back pain, pain in back of both legs and headaches.

**HISTORY OF PRESENT ILLNESS:**

The patient was involved in a motor vehicle accident on 01/06/10. He was a belted driver. While stopped at red light, he was rear-ended at high speed. At that time, he did not feel any of the symptoms noted above and the next morning on awakening, he felt all of the above complaints along with anxiety and panic attacks. He has maintained himself on over-the-counter medications until now.

**MEDICATIONS:**

Over-the-counter pain medications.

**PREVIOUS INJURIES OR ACCIDENTS:**

None.

**PREVIOUS SURGERIES:**

None.

**PRIOR HOSPITALIZATIONS:**

None.

**SOCIAL HISTORY:**

He smokes approximately half a pack of cigarettes a day. He is single.

**WORK HISTORY:**

He is unemployed. He was a cook until approximately two years ago and has not worked since.

**PHYSICAL EXAMINATION:**

The patient is 6 feet 2 inches tall white male weighing approximately 150 pounds. Blood pressure is 112/61. Temperature is 98. Heart rate 108 beats per minute. Examination of

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Patient ID: 1275660

Patient Name:

Date of Birth:

Date of Onset: 01/06/10

Date of Evaluation: 01/20/10

the cardiovascular and respiratory systems appears normal. HEENT: The eyes, ears, nose and throat are normal.

Examination of the spine shows tenderness along the cervical spine diffusely with paraspinal spasms bilaterally. The range of motion of the cervical spine is reduced by 50% in all planes. Examination of the thoracic spine reveals moderate spasm bilaterally. Examination of the lumbar region shows tenderness along the lower lumbar spines at L4 and L5 with paraspinal spasm, which are moderate-to-severe. The range of motion of the lumbar spine is reduced by 50% in all planes.

He reports that the back pain appears to radiate towards the back of both upper legs. He was anxious throughout the examination and he reports occasional panic attacks.

**DIAGNOSES:**

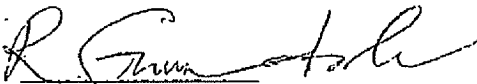
1. Cervical, thoracic, and lumbar strain.
2. Posttraumatic stress syndrome.

**RECOMMENDATIONS:**

1. Physical therapy.
2. Pain medications such as Soma and Xanax twice a day.

**PHYSICAL THERAPY GOALS:**

Short-term and long-term goals are pain management, normalization of tissue tenderness, and restoration of mobility deficits to within functional limits.



Ram Gunabalan, M.D.

Transcribed by JJ Medical Systems

DD: 01/24/10

DT: 01/25/10

PTV/MUK/SHU